

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
0-47
7-39
3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

36770

State File No.

FILED DEC 14 1950

Registration District No. 128

Primary Registration District No. 5465

Registrar's No. 1088

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRINGFIELD, MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WARNICK NURSING HOME R#4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 WEEKS
(years, months or days)

3. (a) PRINT
FULL NAME

GEORGE W. INKS

3. (b) If veteran,
name war _____

3. (c) Social Security No. _____

4. Sex M
race W

5. Color or
race W

6. (a) Single, widowed, married,
divorced M

6. (b) Name of husband or wife
DELLA S. INKS

6. (c) Age of husband or wife if
alive 68 years

7. Birth date of deceased AUG 14 1868
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

82

hr.

min.

9. Birthplace

HICKORY CO
(City, town, or county)

(State or foreign country)

10. Usual occupation

Merchant

11. Industry or business

12. Name

Samuel P. INKS

13. Birthplace

MISSOURI
(City, town, or county)

(State or foreign country)

14. Maiden name

MARY HOGES

15. Birthplace

MISSOURI
(City, town, or county)

(State or foreign country)

16. (a) Informant

MRS. DELLA INKS

(b) Address

PRESTON, MO

17. (a)

BURIAL
(Burial, cremation, or removal)

(b) Date thereof

12-10-1950
(Month) (Day) (Year)

(c) Place: burial or cremation

FISHER

18. (a) Signature of funeral director

Vaughan RESER

(b) Address

URBANE MO

19. (a)

12-9-50
(Date received local registrar)

(b)

W.E. Handley MD
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County HICKORY
(c) City or town PRESTON, MO
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 7
year 1950 hour 1 minute 5 AM.

21. I hereby certify that I attended the deceased from

Dec 12 1946 to 12-7 1950
that I last saw him alive on 12-6 1950
and that death occurred on the date and hour stated above.

Immediate cause of death

Osteo Carcinoma

Duration

2 yrs

Due to

Cancerous Destructure
Left acetabulum, sacrum
Dist 5 lumbar vertebrae

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

(M. D. or other)

Address

Date signed 12-7-50

(Licensed Embalmer's Statement on Reverse Side)

MAR 25 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urbana, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.